Mercer's Education Group Insurance Trust

The Trust was originally started in 1973 to help Private Colleges and Universities pool their lives in order to purchase medical insurance plans. They recognized that the pooling concept would help leverage the pricing of their benefit plans. Their goal was to spread their claims risk over a large number of ee's to minimize the peaks and valleys of their medical insurance renewal. It's risk sharing 101—spread the risk among many.

Mercer's Trust now serves 110+ Private and Public educational institutions. Since 1997 the average renewal action has been 9+%. While no increase is ever wanted, the pooling concept has taken some of the ebb and flow out of renewal rates. If they were insured on a "stand-alone" basis, many of the schools would have had substantial premium increases at renewal due to poor claims experience. By participating in a pooled arrangement, these schools have benefited greatly. In the pooling concept, an institution's individual claims that exceed a certain dollar amount are not used in the experience rating and premium rate calculations for the next plan year. On a stand-alone basis, in any given year, 1 or 2 large claims in a smaller group could adversely affect the premium rates for the following year. Since pooling spreads the risk across many members and excessive individual claims are taken out of the rating formula, rate stability can be achieved for participating groups.

At times there is a misconception that the pooling arrangement reduces the cost of medical claims. This is not the case. A broken arms costs just as much in a pooled group as a non-pooled group if they are insured by the same carrier. Plan cost savings may be realized by administrative efficiencies provided by a carrier. Provider discounts that are obtained by the insurance carrier are usually offered to both pooled and non-pooled groups insured by that particular carrier when they access the same provider network.

Pooling arrangements are successful when they are carefully managed by the broker and. /or Trust Administrator. Additionally, a commitment by participating entities is also very critical. The concept of all for one and one for all cannot be taken too lightly. If in any given year a number of insured groups choose to leave the pool then those remaining are left to pick up the pieces—often times those pieces are groups with high claims utilization and therefore their premium costs will increase more dramatically. Once this happens it sends the pool into a "death spiral" leaving only those groups who can't obtain coverage on their own remaining in the pool and "holding the bag". This places an enormous cost burden on the remaining participants and often time makes the plan unaffordable!

In order to alleviate this situation, some pooling programs require an upfront commitment in momentary incentives or penalties upon withdrawal from the program. Other tactics could include a time certain commitment or in other words mandating that an entity must remain in the pool for the agreed upon time frame.

These options can be successful in keeping the pool fluid but they do little to decrease the cost of medical claims. Aggressive plan designs, wellness plans, disease management programs and plan management can also be used to limit the amount of claims submitted to plan and improve the overall health of individual participants. But it's the health conditions and overall health improvement of active participants that are the leading factors in influencing the true cost any health plan, pooled or not-pooled. If you can make the employees healthier and better purchasers of health care services you have a chance to contain the true cost of any plan.